

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029672

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7871

STATE FILE NUMBER

FILED AUG 15 1963

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis</u>		c. CITY OR TOWN <u>O'Fallon</u>	
Length of stay in lb <u>5 1/2</u> Hours		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Lutheran Hospital (D.O.A.)</u>		d. STREET ADDRESS (If outside, give location) <u>604 S. Walnut</u>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>EDWARD</u> Last <u>BAILEY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-40</u>
9. AGE (last birthday) <u>23</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gluten Feed Dept.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Joseph Bailey</u>		13b. MOTHER'S MAIDEN NAME <u>Agnes Underwood</u>	
14. NAME OF HUSBAND OR WIFE <u>Martha Baur Bailey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>4</u>		17. INFORMANT <u>Mrs. Martha Bailey-604 S. Walnut</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture dislocation of the cervical portion of the spine with partial severance of the spinal cord, suffered when crushed between mailer and floor while working at 721 Reslodge about 4:30 p.m. August 1, 1963.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (a) <u>accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>912.355</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>accident</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>See above</u>	
20c. TIME OF INJURY Hour <u>1:30</u> a.m. <u>8-1-63</u> p.m.		20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Manufacturing Plant</u>		20f. CITY, TOWN, OR LOCATION <u>St. Louis, Mo</u>	
21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at <u>1:30 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Helen L. Taylor, Coroner</u>	
22b. ADDRESS <u>1300 Clark Ave.</u>		22c. DATE SIGNED <u>8-2-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-3-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial</u>	23d. LOCATION (City, town, or county) (State) <u>Belleville Illinois</u>
24. FUNERAL DIRECTOR <u>C. G. Kurrus, Jr</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 2 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_,  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Keith D. Savage*

Licensed Embalmer No. 5180

P. O. Address E. St. Louis, Illinois

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.